Resource Manual Contents

Ladies First Women's Health Screening Program

Ladies First – Member Eligibility

Ladies First members get **FREE** Mammograms, Pap smears and screenings for cholesterol, blood pressure and more. Eligibility is based on:

- Vermont residency
- Age
- Number in household
- Income
- See the back of this page for covered services.

(*Please note women with VHAP, Medicaid, and/or Medicare Part B are not eligible for Ladies First*)

Gross Income for Year 2005 (before taxes)

Number in Household	Yearly	Monthly
1	$23,925	$1,994
2	$32,075	$2,673
3	$40,225	$3,352
4	$48,375	$4,031
5	$56,525	$4,710

For each additional person add $8,150 to yearly income.

Number in household is anyone living in the household that is related by marriage, civil union, or a dependent child related by birth or adoption.

Have your patients call Kate today at: 1-800-508-2222

TDD: 1-800-319-3141

ANNUAL SERVICES for eligible Vermont women

	Age 18–39 (with breast symptoms or abnormal Pap)	Age 40 or older
Screening		
Breast	• Clinical breast exam • Breast self-exam instruction • Screening mammogram	• Clinical breast exam • Breast self-exam instruction • Screening mammogram
Cervical	• Pelvic exam • Pap smear	• Pelvic exam • Pap smear
Cardiovascular	Not available	• Blood pressure check • Total cholesterol • Body Mass Index (BMI) • Diabetic Screening (Glucose)
Diagnostic		
Breast	• Diagnostic mammogram • Ultrasound • Consultation • Second opinion • Breast biopsy	• Diagnostic mammogram • Ultrasound • Consultation • Second opinion • Breast biopsy
Cervical	• Colposcopy • Other diagnostic tests	• Colposcopy • Other diagnostic tests
Cardiovascular	Not available	• Follow-up glucose • Follow-up cholesterol • Lipid panel
And More		
Breast	• Referral to Medicaid Treatment Act, if eligible[+]	• Referral to Medicaid Treatment Act, if eligible[+]
Cervical	• Referral to Medicaid Treatment Act, if eligible[+]	• Referral to Medicaid Treatment Act, if eligible[+]
Cardiovascular	Not available	• Promote and encourage utilization of tailored self-help materials[++]

[+] **The Vermont Breast and Cervical Cancer Medicaid Treatment Program**

Under the federal Medicaid Treatment Act, Vermont began enrolling women directly from Ladies First onto Medicaid in July 2001. The program offers full Medicaid benefits to women during their treatment. Ladies First initiates applications for this program. Providers may receive more information or begin the enrollment process for a patient by calling the Provider Support Line at **1-800-510-2282** and talk with our case manager.

Medicaid Treatment Eligibility Criteria:

1. A woman must be enrolled in Ladies First.
2. A woman must be screened for breast or cervical cancer by Ladies First.
3. A woman must be diagnosed with breast cancer, cervical cancer, or a pre-malignant condition (cervical dysplasia).
4. A woman must require treatment services.
5. A woman must have no other health insurance.
6. A woman must be a US citizen or a qualified alien.
7. A woman must be under age 65.

[++] **Turning Over a New Leaf**

Once CVD screening results are received at Ladies First, women are mailed a letter containing:

- Her results
- Recommended levels
- A three-ring self-help binder addressing ways to improve cholesterol, blood sugar, blood pressure, physical activity, healthy weight and help for smoking cessation. Follow-up is by a Vermont Department of Health nutritionist.

Quit Line tobacco cessation services for Ladies First members include:

- nicotine replacement therapy (gum, patch or lozenge) in conjunction with counseling
- quitting strategies
- a series of phone counseling sessions, and
- referrals to cessation support groups or counseling. Call the Vermont Quit Line (**1-877-937-7848**) or fax referral form to **1-877-747-9528**.

Ladies First – How it Works for Our Members

1 Woman calls Kate at 1-800-508-2222 or TDD 1-800-319-3141 or sees outreach worker. Foreign language and other formats are available.

2 Signs and returns the forms (Consent and Enrollment) that Kate sends them.

3 Receives Ladies First Membership and Screening Cards in the mail. Woman calls a Ladies First doctor or nurse in their area. (Kate can help them find one.)

4 Woman brings Membership and Screening Cards to get health screening, including:

- Clinical breast exam
- Breast self-exam instruction
- Screening mammogram
- Pelvic exam
- Pap test
- Blood pressure*
- Total cholesterol*
- Body Mass Index (BMI)*
- Blood sugar test*

*only for members age 40 and over

5 Woman uses "Mammogram Prescription" to get her mammogram (prescription is attached to the Breast & Cervical screening card).

Find more information at:
www.LadiesFirstVt.org

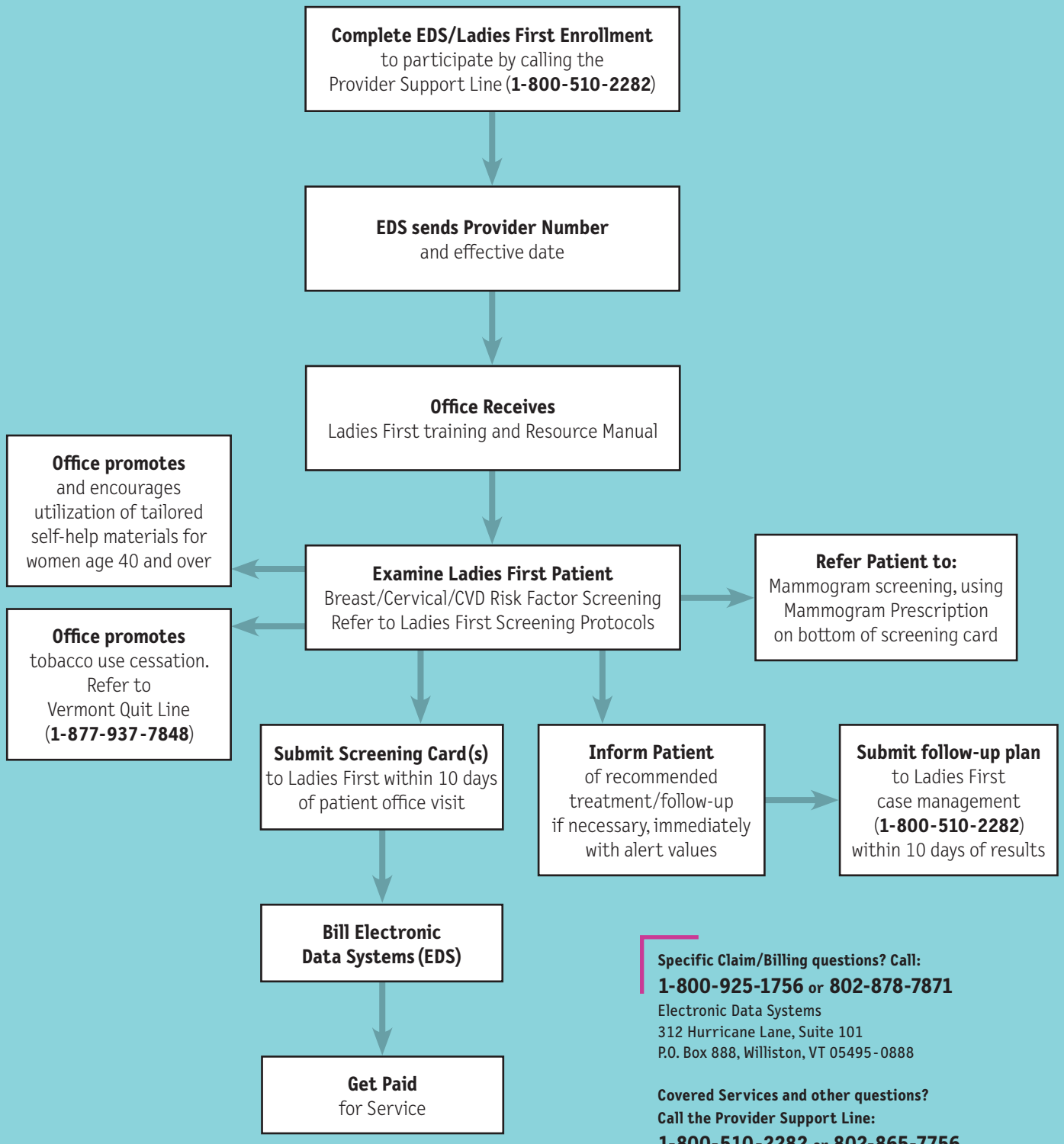
6 Woman receives results of her health tests. If she needs follow-up or treatment, Ladies First will help. The Provider office notifies Ladies First.

7 Woman receives mailed, tailored self-help materials.

8 One year later, Kate will send re-enrollment forms and new screening card(s). Woman gets screened again.

Ladies First – How it Works for Health Care Providers

AS OF JULY 1, 2005



Specific Claim/Billing questions? Call:

1-800-925-1756 or 802-878-7871

Electronic Data Systems
312 Hurricane Lane, Suite 101
P.O. Box 888, Williston, VT 05495-0888

Covered Services and other questions?
Call the Provider Support Line:

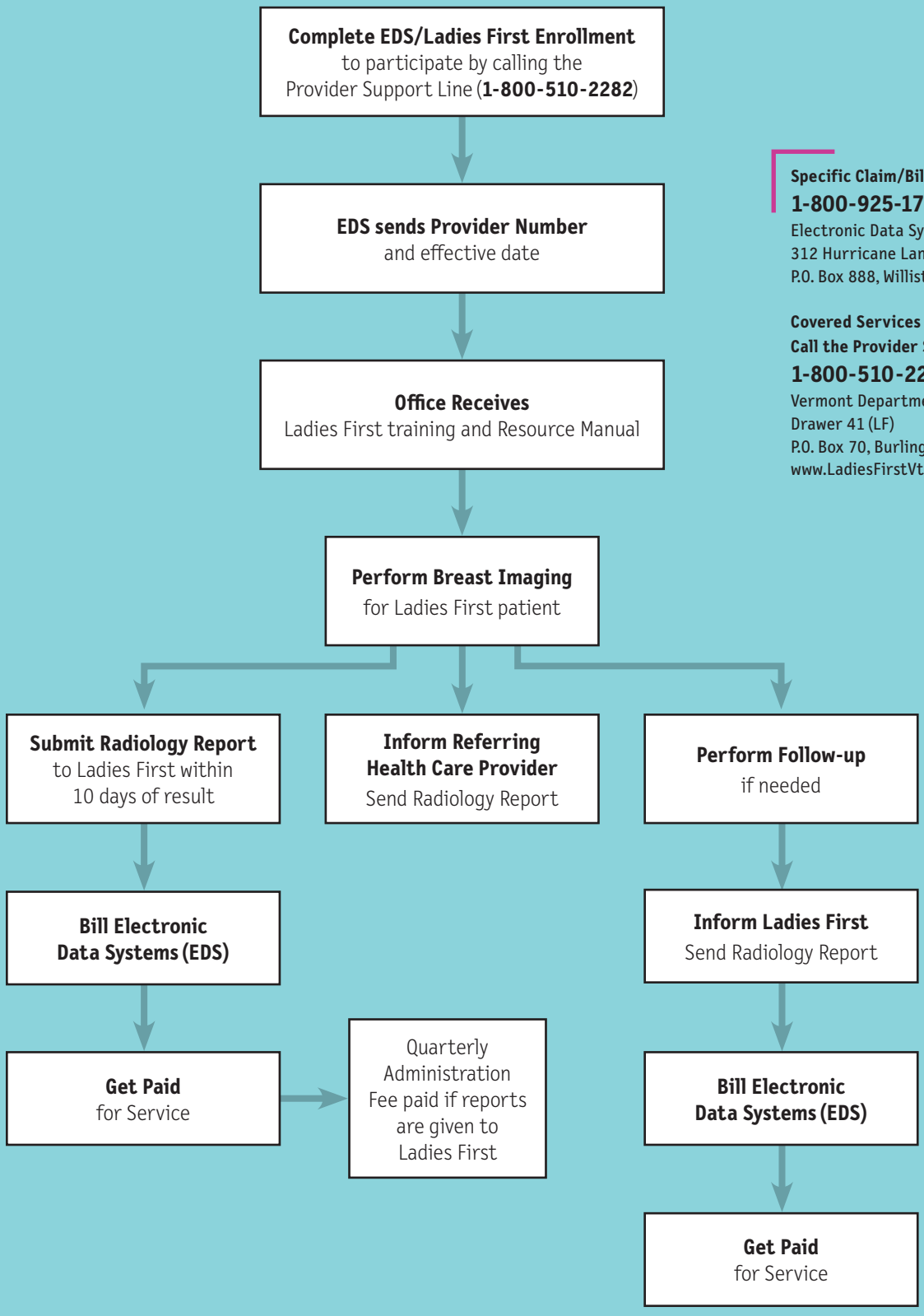
1-800-510-2282 or 802-865-7756

Vermont Department of Health
Drawer 41 (LF)
P.O. Box 70, Burlington, VT 05402-9962
www.LadiesFirstVt.org

AAG3-7/1/05

Ladies First – How it Works for Mammography Facilities

AS OF JULY 1, 2005



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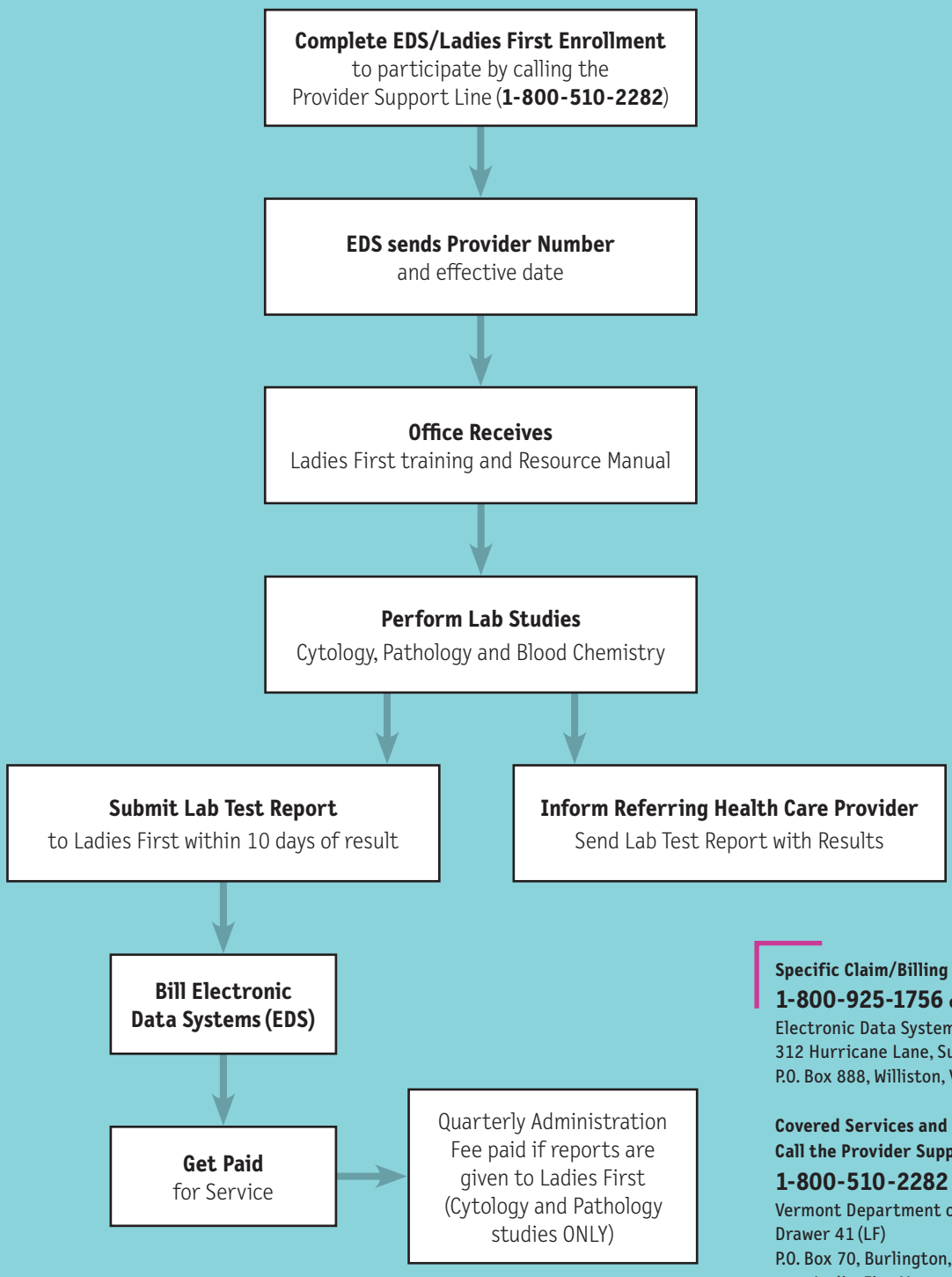
Ladies First – How it Works for Laboratories

AS OF JULY 1, 2005



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Introduction to the Ladies First Program

The Ladies First Program is federally funded by the Centers for Disease Control and Prevention (CDCP) to provide access to life saving screening exams and lifestyle intervention programs for uninsured or underinsured Vermont women who are of limited income. The program is authorized to pay for procedures related to screening for and diagnosis of breast cancer, cervical cancer and cardiovascular disease risk factors.

Providers send to Ladies First Central Office:

- Screening cards for office visits
- Lab reports
- Radiology reports
- Tests related to the procedures being billed

This is the data submitted to the CDCP (with all identifying information removed) and are used to determine the program's funding level. This data is necessary for audits from the CDCP and the State of Vermont. All payments must be for eligible services as stated in the guidelines from the CDCP.

Beginning July 1, 2005, EDS will be processing all claims for the Ladies First Program. Enclosed in this manual are detailed instructions on how to bill EDS for Ladies First covered services.

This information guide, in conjunction with the NHIC web site (www.medicarenhic.com), Provider Newsgrams from Ladies First, special mailings, and other specialty guides, provide the information you need to stay informed of Ladies First services and procedures. Help is always available from our Provider Support Line at 1-800-510-2282. All information is subject to change as Federal regulations and CDCP guidelines are revised.

If you have questions or suggestions regarding this material, please call our Provider Support Line at 1-800-510-2282.

Enroll a Woman at Your Office

Most women have enrolled in Ladies First prior to the office visit. If, however, a woman arrives at your office for an exam and doesn't know about Ladies First – you can help. If you think a patient may be eligible and in need of Ladies First services, encourage her to call Kate at 1-800-508-2222 or (TDD 1-800-319-3141) from your office. She can be enrolled immediately. (If a patient has VHAP, Medicaid or Medicare Part B, she is not eligible for our services.)

Chart sticker

Enrollment card

Prepare for an Office Visit with a Ladies First Member

When a patient arrives for her health exams, ask for her Ladies First program enrollment card and screening card(s). Members cannot get screened without them! There are two separate screening cards – a teal one for breast and cervical screening and a purple one for heart health screening for women 40 and over (see at right). The cards describe the services they get at their doctor visit. Women over 40 get both cards, and those under 40 get only the teal card. Members are instructed to bring the card(s) to their appointment. Complete the information and fax or mail the card(s) to us. One year later, when it is time to get screened again, Kate will send the member a new card(s).

Attach the card(s) to the patient's file, along with stickers for her chart and any lab requisitions such as Pap smear, blood glucose, or other scheduled screenings. The screening card(s) are the only form you need to record the office exam. Be sure to send the card(s) to Ladies First within 10 days of the patient's visit.

Screening cards

If a Ladies First member presents for her appointment without her screening card(s) call our Provider Support Line at 1-800-510-2282 to have one faxed to you.

General Information

Medical Record Documentation

The purpose of medical record documentation, in general, is to provide a permanent record of each patient's medical condition and treatment for medical, legal and financial reasons. Documentation must be as clear and complete as possible, so that it may be read and understood accurately. Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time.
- Continuation and continuity of care among physicians and other health care professionals involved in the patient's care.
- Appropriate utilization review and quality of care evaluations.
- The collection of data that may be useful for research and education.

Ladies First Screening Cards for office visits, lab reports, radiology reports, other tests related to the procedures being billed, and provider notes with plans for follow-up (needed for case management) must be submitted to Ladies First. The CDCP mandates that Ladies First keeps a record of these reports as proof of services paid for.

Submission by mail:
Vermont Dept. of Health
Ladies First
108 Cherry Street
Drawer 41 (LF)
Box 70
Burlington, VT 05402-9962

Submission by fax: (802) 657-4208

CPT codes and ICD-9-CM codes reported on health insurance claim forms should be supported by the documentation in the medical record. Ladies First and the CDCP insist on accurate medical record documentation to ensure members have received quality care and that services reported are consistent with the coverage provided.

HIPAA

The Health Insurance Portability and Accountability Act, better known as HIPAA, is a federal law created in 1996 to reform the health insurance market and simplify health care transactions and processes. The law requires that any provider who electronically sends or receives certain transactions must send or receive them in a standard format. The three (3) major components to HIPAA are: Transactions and Code Sets, Privacy and Security. The following telephone number, e-mail and website addresses will provide information or answer questions to assist you in complying with the requirement:

ASKHIPAA (866) 282-0659
askhipaa@cms.hhs.gov
www.cms.hhs.gov/hipaa
www.nhvship.org

Submitting Bills and Filing Electronically

All bills for Ladies First members on or after date of service July 1st, 2005 should be sent directly to Electronic Data Systems (EDS) in Williston. EDS provides business and technology solutions to help clients improve their business performance. Paper bills may be submitted via mail to:

EDS
312 Hurricane Lane – Suite 101
PO Box 888
Williston, VT 05495-0888

Bills may also be submitted electronically as long as the provider has completed the Trading Partner Agreement and EDI Registration forms. (A brief overview can be located on the next page. The complete instructions may also be found on their website at: www.vtmedicaid.com.) Click on Downloads and then click on Software, then click information and select "PES Guide." Reminder that bills past one year from date of service will be denied.

Bills for dates of services provided prior to July 1, 2005 should still be sent to:

VT Department of Health
Ladies First Program
Drawer 41 (LF)
PO Box 70
Burlington, VT 05402-9962

All clinical and screening information should still be sent to Ladies First at the above listed address regardless of the service date. This information may also be faxed to (802) 657-4208.

To bill EDS, you will need to use your Ladies First Provider number. This number is obtained by completing the Ladies First/EDS provider enrollment form. This number will be mailed to you once you are in EDS's system. Claims will be denied if they are billed to EDS using your Medicaid Provider number for a Ladies First member.

Provider Electronic Solutions (PES) Overview

Many providers have electronic submission capabilities built into their billing systems. You will now be able to utilize this functionality to submit 837 electronic claims to EDS for your Ladies First services. If electronic billing is not included in your billing system, you may utilize EDS' free software, PES, to enter your electronic claims to then submit to EDS. The PES program is designed to provide the billing provider with a faster and more efficient method of transaction submission and processing. Handling time and errors are reduced, eliminating delays in processing and decreasing turn-around times. PES is a transaction entry software package developed by EDS that meets the standards implemented by HIPAA. The software allows for electronic transaction submission directly to the Northeast Regional HIPAA Translator.

PES Software Media

The PES application programs and files are located on EDS web site at www.vtmedicaid.com. Click on Downloads and then click on Software to access the appropriate web page.

Step by step instructions for completing the 837 electronic form can be found on the website by clicking on the "INFORMATION" tab and then selecting the "PES GUIDE."

Information for All Providers

Health Care Providers

- Screening report cards and provider notes with plans for follow up should be sent to Ladies First.
- EDS will reimburse for procedures listed on the current schedule of fees for covered services distributed annually by the program with corresponding ICD-9-CM codes. Ladies First pays for breast and cervical cancer screening and diagnostic procedures and some cardiovascular risk factor screenings. In the appendix, please find the current list of CPT and ICD-9-CM codes. These codes are subject to change annually in accordance with CDCP guidelines.
- Ladies First will only pay for two cardiovascular disease risk factor appointments per year for members who are 40 years of age and over. One screening visit must include two blood pressure results, height, and weight, and a cholesterol test (This can be done either in the office or a woman might be sent to a lab); the other is for a diagnostic or follow-up visit. You may bill labs corresponding to CPT codes: 80061, 82465, 82947, 82948, 83036, 83718, and 83721. The office visits billed must also use one of the ICD-9-CM codes that correspond to a cardiovascular diagnosis which are shaded in grey on our ICD-9-CM code list attached.
- The breast and cervical component of Ladies First will pay for annual gynecological exam screenings and breast or cervical cancer diagnostic visits necessary to make a diagnosis. This component applies to all Ladies First members regardless of age. The program is only allowed to pay for gynecological procedures that are related to breast or cervical cancer screening.
- EDS will pay up to the rate of reimbursement allowed by Ladies First, which is the Medicare Part B rate. Providers agree to write-off any remaining balance related to Ladies First covered procedures and not bill the member (this is counted as "match" for the Ladies First Program). The CDCP mandates that Ladies First Program has match 1:3, which equals one dollar for every three dollars of federal funds.
- If a woman has insurance, *the insurance must be billed first, even if you are certain the bill will be denied*. The CDCP mandates that Ladies First is the payer of last resort which we have to prove at annual audits. *The Explanation of Benefits (EOB)* is the proof needed, therefore *must be submitted with the bill*. EDS will pay the difference between what the insurance paid on the Ladies First procedure, up to the Medicare Part B rate. Again, any remaining balance will not be billed to the member.
- Supplementation does *not* apply to Ladies First members. You may bill the member for services that are not covered by Ladies First; however, as stated above, for Ladies First covered procedures, **you must write-off** the difference between what is reimbursed and the remaining amount.

Hospital Providers

- CPT codes need to be used on the UB-92 Claim Form in addition to revenue codes for specific services. Please refer to the attached list of revenue codes to determine which require CPT codes.
- Revenue codes will be three characters. Modifier "26" or "TC" must be used appropriately when billing the physician services on the HCFA 1500 Claim Form. Hospitals will be paid the technical component.

Lab and Mammography Facilities

- Send all Lab and Radiology reports to Ladies First within 10 days of results.
- The Ladies First $5.00 "administrative fees" will be paid on a quarterly basis. Ladies First will verify that the clinical data has been received, and then EDS will be notified to send payment in a lump sum to the facility for radiology, cytology and pathology reports *only*.

- Modifiers 26 will be required on the HCFA 1500 Claim Form for all mammograms and surgical pathology. When billing on the UB-92 Form the technical component will be reimbursed.

Anesthesiologists

- Procedure code 00400 will be billed at $100= 1 unit if the service relates to a Ladies First covered diagnosis.
- Pharmacy charges and supplies billed need to have revenue codes from the attached list.

ICD-9-CM

ICD-9-CM is the only diagnostic coding system accepted for Ladies First billing. The code chosen must be used to the highest level of specificity and should accurately describe the patient's illness, disease or signs and symptoms.

Completing the HCFA 1500 Claim Form

(See sample form in Appendix)

All information on the HCFA 1500 Claim Form should be typed or legibly printed. **Only the 12-90 version of this form is accepted for processing.** The fields listed below are used by EDS when processing Ladies First claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. The fields not listed below are not used by the Ladies First Program and do not need to be completed.

FIELD LOCATOR	REQUIRED INFORMATION
1. Carrier Identification	Check the "Other" box.
1a. Insured's ID Number*	Enter the member's nine-digit social security number.
2. Patient's Name*	Enter the patient's last name, first name and middle initial.
3. Patient's Birth Date	Enter the date of birth in MM/DD/YY format; check the appropriate box to indicate patient's sex. If the member was born in any century other than the 1900's, enter the date of birth in a MM/DD/CCYY format.
5. Patient's Address	Enter the street (Not P.O. Box), city, state and zip code.
10. Condition Related to *	Check the appropriate box to indicate: a. If condition is related to employment; b. If condition is related to an auto accident; c. If condition is related to any other type of accident. If "Yes" is checked in any of these boxes, enter the accident date in field 14.
11. Insured's Policy Number	If the member has other health insurance, enter the applicable policy number: a. Enter the insured's date of birth in MM/DD/YY format; check the appropriate box to indicate insured's sex; b. Enter the insured's employer or school name; c. Enter the name of the other health insurance carrier.
14. Date of Current	If any box in 10a, 10b or 10c indicates a "Yes" response, enter the date of the accident. Required if "yes" is entered.
21. Diagnosis Code(s)*	Enter the appropriate ICD-9-CM diagnosis code that relates to the service rendered. You may use up to four (4) diagnosis codes. (see Fee Schedule tab for ICD-9-CM code list)
24a. Date(s) of Service*	Enter the date of each service provided. If the "From" and "To" dates are the same, the "To" date is not required. MM/DD/YY format.
24b. Place of Service*	Enter the appropriate two-digit place of service code. You must use codes 11, 22 or 23. "Code 3" will be denied.
24d. Procedure Code*	Enter the appropriate procedure code and applicable modifiers to explain the service rendered. (see Fee Schedule tab for CPT code list)
24e. Diagnosis Pointer*	Enter the appropriate diagnosis "pointer" that relates to the service rendered (i.e. 1, 2, 3, 4), and that corresponds to the diagnosis from Field 21. To be reimbursed for Ladies First procedures, both the diagnosis code and the CPT code must be Ladies First codes.

24f. Charges*	Enter the usual and customary charge for the service rendered.
24g. Days or Units*	Enter the number of days or units of service which were rendered. (**Reminder: anesthesia is $100= 1 unit**)
24k. Local Use*	Enter the attending physician's Ladies First provider number. **Do not** use your Medicaid provider number, as claims will be denied. This must be entered on each line being submitted for reimbursement.
26. Patient's Account Number	Enter the account number you have assigned to the patient. EDS can accept up to 20 digits; alpha, numeric, or alpha/numeric in this field. This information will print on the RA summary for your accounting purposes.
28. Total Charge*	Add the charges from field 24f for each line and enter the total in this field. The sum of the detail charges must add up to the total charges exactly. If they do not, the claim will be denied.
29. Amount Paid*	Enter the amount paid by other health insurance coverage (for Ladies First procedures only). If there is an amount in this field, then, fields 11a, 11b and 11c must also be completed. The amount paid must have only the "amount paid" by the insurer and not include the "reduction". If this box includes the "reduction", that will be counted as part of the insurance payment and be deducted from what EDS will pay. EDS will pay only up to the Medicare Part B rate after deducting what the primary health insurance paid. If a service submitted involves other insurance, it must be submitted as a one detail claim to appropriately process the payment from the insurance company. If there are several services provided on the same day that involve insurance payments, you will need to submit a separate claim for each service the other insurance payment received in field 29. Electronically submitted claims can be submitted as multiple details since there is a field for the other insurance payment at the detail level.
31. Signature*	Enter the provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature.
33. Billing Provider*	Enter the **payee** provider name, address and provider number as it appears on the Provider Identification Record (**as requested on the enrollment form**). Enter only the seven-character Ladies First provider number of the **payee** provider. Do not enter more than one ID number in this box.

Completing the UB-92 Claim Form

(See sample form in Appendix)

All information on the UB-92 claim form should be typed or legibly printed. The fields listed below are used by EDS when processing Ladies First claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. The fields not listed below are not used by the Ladies First Program and do not need to be completed.

Note: Only revenue codes on the attached list will be accepted for payment. A "Date of Service" must be entered for each line item submitted for reimbursement.

FIELD LOCATOR	REQUIRED INFORMATION
1. Unlabeled Field*	This field is for the provider number and address.
2. Unlabeled Field	Not used.
3. Patient Control Number	For accounting purposes, enter the patient's medical record number. The medical record number may consist of up to 20 characters, alpha/numeric. The information will appear on the RA.
4. Type of Bill*	For outpatient values use 131-135 for patient services or 141 for non-patient services.
6. Statement Covers Period*	Enter the beginning and ending service dates included on the bill. On electronic claims, enter dates in a MM/DD/CCYY format. On paper claims, enter dates in a MM/DD/CCYY format.
12. Patient's Name*	Enter the patient's last name, first name and middle initial.
14. Patient's Birth Date	Enter the date of birth. On electronic claims, the date must be in MM/DD/CCYY format. On paper claims, if the recipient was born in any century other than the 1900's, enter the date of birth in a MM/DD/CCYY format. Otherwise, the date must be entered in MM/DD/YY format.
15. Sex	Enter recipient's sex: F-Female
17. Admission Date*	Date patient admitted. Ladies First will not cover overnight stays.
18. Admission HR*	Time patient admitted to facility.
19. Admission Type*	1= Emergency, 2= Urgent, 3= Elective, 4= Newborn. The provider will enter the value that is correct for the service being billed.
32. Occurrence Code and Date*	Enter date in MM/DD/YY format if accident related.
42. Revenue Code*	Enter the appropriate three-digit revenue code for the service described. To be reimbursed for Ladies First services, this must be a revenue code included on the list of covered services (see Fee Schedule tab for revenue code list).
43. Description*	Enter description of the related revenue categories included on this bill.
44. HCPCS/Rates	Enter the corresponding CPT procedure code for lab, radiology or ambulatory surgical procedures. Ladies First does not cover HCPCS codes (see Fee Schedule tab for CPT code list).

45. Service Date*	Enter the actual date of service rendered. A service date must be entered for each line item submitted for reimbursement.
46. Service Units*	Enter the quantitative measure of services rendered per revenue code. (Reminder: anesthesia is $100= 1 unit)
47. Total Charges*	Enter total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of the column.
50. Payer	This field is for other insurance company name. Enter "Insurance company name"– If other insurance is involved, enter the carrier code(s) on the corresponding line.
51. Provider Number*	Enter your Ladies First Provider Number on Line C.
54. Prior Payments	Enter the amount paid by other health insurance coverage (for Ladies First procedures only). The amount paid must have only the "amount paid" by the insurer and not include the "reduction." If this box includes the "reduction," that will be counted as part of the insurance payment and deducted from what EDS will pay. Ladies First will pay only up the Medicare Part B rate. If a service submitted involves other insurance, it must be submitted as a one detail claim to appropriately process the payment from the insurance company. If there are several services provided on the same day that involve insurance payments, you will need to submit a separate claim for each service showing the other insurance payment received in field 54. Electronically submitted claims can be submitted as multiple details since there is a field for the other insurance payment at the detail level.
55. Est. Amount Due*	Enter amount due after deducting any amount entered in form locator 54 from the total entered at the bottom of column 47.
60. Cert-SSN-HIC-ID. Number*	Enter the recipient's nine-digit social security number.
67. Prin Code*	Enter the Primary Diagnosis Code. Use the appropriate ICD-9-CM code. To be reimbursed for Ladies First procedures, you must use Ladies First ICD-9-CM codes. (see Fee Schedule tab for ICD-9-CM code list)
68 - 75. Other Diagnosis Codes	Enter the appropriate ICD-9-CM code for any condition other than primary which requires supplementary treatment. To be reimbursed for Ladies First procedures, you must use Ladies First ICD-9-CM codes.
82. Attending Physician ID*	Enter the individual Attending Physician's Ladies First Provider Number. Do not use your Medicaid provider number, as claims will be denied.
84. Remarks	Enter any notations relating specific information necessary to adjudicate the claim.
85. Provider Representative*	Enter the provider's signature or facsimile of an authorized representative of the facility.
86. Date*	Enter date on which the claim was signed or sent to payer for payment.

Other Items to Note

- Revenue codes used with or without a CPT code must be submitted on a UB-92 Claim Form. Procedures submitted on an HCFA 1500 Claim Form must all have CPT codes and applicable modifiers or they will be denied.
- If a Facility and Non-Facility bill is for the same service, it is considered double billing and only one will be paid for said service. The other one will be denied.
- Remember Ladies First *cannot* pay for the following non-CDCP covered procedures:
  a. Pelvic and trans-vaginal ultrasound
  b. Vaginal biopsy
  c. Vulvar biopsy
  d. Endometrial biopsy (unless patient has Atypical Glandular cells of undetermined significance Pap smear results, then we can cover)
  e. LEEP, cervical conization (can be covered by the Vermont Breast and Cervical Medicaid Treatment Program if eligible)
  f. Breast MRI

What to Expect from EDS

- Clean claims (those that do not set any edits) processed within 10 days
- Sample remittance advice (You can see examples in the EDS billing manual at www.vtmedicaid.com)
- Workshops and provider notification of EDS systems changes via their advisory. The advisories are published every two months and are available on the www.vtmedicaid.com website.

Contact Information

- EDS will accept phone calls for specific claim/billing questions 1-800-925-1756 or (802)878-7871.

EDS
312 Hurricane Lane – Suite 101
PO Box 888
Williston, VT 05495-0888

- Ladies First will accept phone calls on covered services, Ladies First eligibility, and all other provider questions at our Provider Support Line 1-800-510-2282 or (802) 865-7756.

Schedule of Fees for Covered Services

Effective from Date of Service 01/01/05

CPT Code	Description	Non-Facility Fee	Facility Fee
00400	Anesthesia (per unit) (Unit = $100.00)	$18.53	$18.53
10021	FNA – no image guidance	$141.68	$76.56
10022	FNA – using image guidance	$157.02	$71.28
19000	Incision – aspiration of cyst in breast	$116.58	$49.02
19001	Incision – aspiration of additional cyst in breast	$28.35	$23.91
19100	Needle breast biopsy	$140.13	$72.98
19101	Incisional breast biopsy	$321.77	$217.02
19102	Needle biopsy using image guidance	$240.71	$112.48
19103	Automated vacuum assisted breast biopsy	$623.93	$208.92
19120	Excision of cyst, fibroadenoma or tumor – **REVIEW REQUIRED**	$428.75	$368.90
19125	Excision of breast lesion with radiological marker	$460.66	$399.97
19126	Exicisional biopsy of additional breast lesion – using radiological marker	$169.86	$169.86
19290	Preoperative placement of needle localization wire (breast) – TC	$169.57	$71.28
19291	Preoperative placement of needle localization wire (breast) – each additional lesion	$75.89	$35.43
19295	Image-guided placement of localization clip	$109.02	$109.02
36415	Venipuncture for blood test	$3.00	$3.00
57452	Colposcopy of cervix	$117.50	$96.47
57454	Colposcopy with biopsy of cervix and endocervical curettage	$168.77	$148.95
57455	Colposcopy with biopsy of cervix	$157.08	$122.69
57456	Colposcopy with endocervical curettage	$148.03	$114.45
57500	Biopsy of cervix	$145.25	$67.99
57505	Endocervical curettage	$109.02	$94.46
58100	Endometrial sampling (biopsy) – **REVIEW REQUIRED**	$120.57	$96.30
71020	Chest x-ray – **REVIEW REQUIRED**	$38.09	$38.09
71020 26	Chest x-ray – PC – **REVIEW REQUIRED**	$12.14	$12.14
76090	Unilateral diagnostic mammogram	$82.67	$82.67
76090 26	Unilateral diagnostic mammogram – PC	$38.93	$38.93
76090 TC	Unilateral diagnostic mammogram	$43.76	$43.76
76091	Bilateral diagnostic mammogram	$102.67	$102.67
76091 26	Bilateral diagnostic mammogram – PC	$48.20	$48.20
76091 TC	Bilateral diagnostic mammogram	$54.49	$54.49
76092	Bilateral screening mammogram	$90.16	$90.16
76092 26	Bilateral screening mammogram – PC	$38.93	$38.93
76092 TC	Bilateral screening mammogram	$51.24	$51.24
76095	Stereotactic localization guidance for breast biopsy	$386.29	$386.29
76095 26	Stereotactic localization guidance for breast biopsy – PC	$88.87	$88.87
76095 TC	Stereotactic localization guidance for breast biopsy	$297.49	$297.49
76096	Mammographic guidance for needle placement, biopsy of breast	$85.58	$85.58
76096 26	Mammographic guidance for needle placement, biopsy of breast – PC	$31.11	$31.11
76096 TC	Mammographic guidance for needle placement, biopsy of breast	$54.49	$54.49

CPT Code	Description	Non-Facility Fee	Facility Fee
76098	Radiological examination of surgical specimen – **REVIEW REQUIRED**	$26.28	$26.28
76098 26	Radiological examination of surgical specimen – PC – **REVIEW REQUIRED**	$8.86	$8.86
76098 TC	Radiological examination of surgical specimen – **REVIEW REQUIRED**	$17.41	$17.41
76645	Ultrasound of breast	$73.81	$73.81
76645 26	Ultrasound of breast – PC	$30.06	$30.06
76645 TC	Ultrasound of breast	$43.76	$43.76
76942	Ultrasonic guidance for needle placement, biopsy of breast	$153.07	$153.07
76942 26	Ultrasonic guidance for needle placement, biopsy of breast – PC	$37.27	$37.27
76942 TC	Ultrasonic guidance for needle placement, biopsy of breast	$115.79	$115.79
76970	Breast Ultrasound – follow-up study	$66.00	$66.00
76970 26	Breast Ultrasound – follow-up study – PC	$22.24	$22.24
76970 TC	Breast Ultrasound follow-up study	$43.76	$43.76
80061	Lipid panel	$15.34	$15.34
82465	Blood cholesterol, total	$6.08	$6.08
82947	Blood glucose, quantitative	$5.48	$5.48
82948	Blood glucose, reagent strip	$3.57	$3.57
83036	Hemoglobin assay – **REVIEW REQUIRED**	$13.56	$13.56
83718	Blood high-density lipoprotein (HDL) cholesterol	$8.06	$8.06
83721	Blood low-density lipoprotein (LDL) cholesterol	$12.81	$12.81
87621	Human papillomavirus (HPV) amplified probe	$36.39	$36.39
88104	Cytopathology of fluids (non cervical)	$58.42	$58.42
88104 26	Cytopathology of fluids (non cervical) – PC	$33.33	$33.33
88104 TC	Cytopathology of fluids (non cervical)	$25.10	$25.10
88141	Cytopathology, cervical, requiring interpretation by physician	$23.89	$23.89
88142	Cytopathology, cervical, liquid-based thin-prep	$14.76	$14.76
88150	Cytopathology, cervical or vaginal, manual screening of slides – **REVIEW REQUIRED**	$14.76	$14.76
88160	Cytopathology, non-cervical, manual screening and interpretation of slides.	$55.13	$55.13
88160 26	Cytopathology, non-cervical, manual screening and interpretation of slides – PC	$29.61	$29.61
88160 TC	Cytopathology, non-cervical, manual screening and interpretation of slides	$22.51	$22.51
88161	Cytopathology, non-cervical, preparation, screening and interpretation	$59.57	$59.57
88161 26	Cytopathology, non-cervical, preparation, screening and interpretation – PC	$29.61	$29.61
88161 TC	Cytopathology, non-cervical, preparation, screening and interpretation	$29.96	$29.96
88162	Cytopathology, extended study involving over 5 slides	$73.78	$73.78
88162 26	Cytopathology, extended study involving over 5 slides – PC	$45.46	$45.46
88162 TC	Cytopathology, extended study involving over 5 slides	$28.34	$28.34
88164	Cytopathology, Pap smear, screening and interpretation	$14.76	$14.76
88172	Cytopathology – FNA evaluation and determination of adequacy	$55.22	$55.22
88172 26	Cytopathology – FNA evaluation and determination of adequacy – PC	$35.78	$35.78
88172 TC	Cytopathology – FNA evaluation and determination of adequacy	$19.44	$19.44
88173	Cytopathology – FNA interpretation and report	$145.61	$145.61
88173 26	Cytopathology – FNA interpretation and report – PC	$82.49	$82.49
88173 TC	Cytopathology – FNA interpretation and report	$63.12	$63.12
88175	Cytopathology, cervical or vaginal, automated screening of slides – **REVIEW REQUIRED**	$37.01	$37.01
88305	Surgical pathology, Level IV – **REVIEW REQUIRED**	$109.80	$109.80
88305 26	Surgical pathology, Level IV – PC – **REVIEW REQUIRED**	$45.05	$45.05

CPT Code	Description	Non-Facility Fee	Facility Fee
88305 TC	Surgical pathology, Level IV – **REVIEW REQUIRED**	$64.77	$64.77
88321	Surgical pathology, consultation on slides prepared elsewhere	$86.85	$77.54
88331	Surgical pathology, consultation during surgery – **REVIEW REQUIRED**	$95.46	$95.46
88331 26	Surgical pathology, consultation during surgery – PC – **REVIEW REQUIRED**	$70.75	$70.75
88331 TC	Surgical pathology, consultation during surgery – **REVIEW REQUIRED**	$24.71	$24.71
90780	Intravenous infusion (IV) – **REVIEW REQUIRED**	$125.00	$125.00
93000	Electrocardiogram (ECG) – **REVIEW REQUIRED**	$28.30	$28.30
99201	Office visit – new patient (10 minutes)	$39.09	$25.33
99202	Office visit – new patient (20 minutes)	$69.45	$50.04
99203	Office visit – new patient (30 minutes)	$103.11	$76.81
99204	Office visit – new patient (45 minutes)	$146.04	$114.08
99205	Office visit – new patient (60 minutes) – **REVIEW REQUIRED**	$185.13	$151.96
99211	Office visit – established patient (5 minutes) – **REVIEW REQUIRED**	$23.03	$9.68
99212	Office visit – established patient (10 minutes)	$41.11	$25.74
99213	Office visit – established patient (15 minutes)	$56.28	$38.09
99214	Office visit – established patient (25 minutes)	$88.27	$63.19
99215	Office visit – established patient (40 minutes)	$128.37	$101.28
99241	Office consultation – new or established patient (15 minutes)	$53.44	$36.46
99242	Office consultation – new or established patient (30 minutes)	$97.60	$74.15
99243	Office consultation – new or established patient (40 minutes)	$130.20	$99.46
99244	Office consultation – new or established patient (60 minutes) – **REVIEW REQUIRED**	$183.85	$147.44
99245	Office consultation – new or established patient (80 minutes) – **REVIEW REQUIRED**	$237.89	$196.22
99385	Initial comprehensive preventive medicine visit – new patient (18-39 years)	$125.75	$87.23
99386	Initial comprehensive preventative medicine visit – new patient (40-64 years)	$147.84	$106.91
99387*	Initial comprehensive preventive medicine visit – new patient (65+ years)	$160.38	$117.04
99395	Periodic comprehensive preventive medicine visit – established patient (18-39 years)	$102.97	$77.29
99396	Periodic comprehensive preventive medicine visit – established patient (40-64 years)	$113.72	$87.23
99397*	Periodic comprehensive preventive medicine visit – established patient (65+ years)	$125.46	$97.26

***Only for women 65+ without Medicare-B**

NOTE: EXTRA CHARGES are paid only per itemized review

ICD-9-CM Codes

Effective January 1, 2005

√4th	174		Malignant neoplasm of the female breast
		174.0	Nipple and areola
		174.1	Central portion
		174.2	Upper, inner quadrant
		174.3	Lower, inner quadrant
		174.4	Upper, outer quadrant
		174.5	Lower, outer quadrant
		174.6	Axillary tail
		174.9	Unspecified
	180.8		Malignant neoplasm – other specified cites of the cervix
	217		Benign neoplasm of breast
	219.0		Benign neoplasm of cervix uteri
√4th	233		Carcinoma is situ of breast and genitourinary system
		233.0	Breast
		233.1	Cervix uteri
		239.3	Neoplasm of unspecified nature – breast
*	250.00		Unspecified dm
*	250.01		Dm, type 1
*	250.02		Dm, type 2
*	250.0		Dm, type 1, uncontrolled
*	250.90		Dm with unspecified complication
*	272.0		Pure hypercholesterolemia
*	272.2		Disorders of lipid metabolism
*	272.4		Unspecified hyperlipidemia
*	272.9		Unspecified disorders of lipid metabolism
*	278.00		Obesity
*	278.01		Morbid obesity
*	401.0		Malignant essential htn
*	401.1		Benign essential htn
*	401.9		Unspecified essential htn
*	405.09		Secondary htn, malignant
*	405.19		Secondary htn, benign
*	405.99		Secondary htn, unspecified
*	429.2		Cardiovascular disease, unspecified
√4th	610		Benign mammary dysplasia
		610.0	Solitary cyst
		610.1	Diffuse cystic mastopathy
		610.2	Fibroadenosis
		610.3	Fibrosclerosis
		610.4	Mammary duct ectasia
		610.8	Specified benign mammary dysplasia
		610.9	Unspecified benign mammary dysplasia
√4th	611		Other disorders of breast
		611.0	Inflammatory
		611.1	Hypertrophy
		611.2	Fissure of nipple
		611.3	Fat necrosis

CVD reimbursement:

Ladies First will pay for one CVD "screening visit" that **MUST** include a cholesterol test.

The program will reimburse for one additional CVD diagnostic office visit in a 310-day period.

* These cardiovascular disease screening codes are billable **ONLY** for women 40 years of age and older.

√4th Denotes that a fourth digit is needed to bill for the code in a specific manner.

		611.4	Atrophy
		611.5	Galactocele
		611.6	Galactorrhea not associated with childbirth
		611.71	Mastodynia
		611.72	Lump or mass
		611.79	Other symptoms
		611.8	Specified disorders of the breast
		611.9	Unspecified disorders of the breast
	616.0		Cervicitis and endocervicitis
	622.10		Dysplasia of cervix
	622.11		Mild dysplasia of cervix
	622.12		Moderate dysplasia of cervix
	622.7		Mucous polyp of cervix
	757.6		Disorders of skin, breast
*	**790.21**		Impaired fasting glucose
*	**790.29**		Abnormal glucose
	793.80		Abnormal mammogram
	793.81		Mammographic microcalcification
	793.89		Abnormal findings on radiological examination of breast
	795.00		Agus Pap
	795.01		Ascus Pap
	795.02		Asch Pap
	795.03		Lgsil Pap
	795.04		Hgsil Pap
	795.05		High risk hpv, dna test
	795.08		Unsatisfactory Pap
	795.09		Pap with low risk hpv type
*	**796.2**		Other specified abnormal findings, elevated bp w/o htn
	V10.3		Potential health hazard related to personal or family dx, breast
	V10.41		Potential health hazard related to personal or family dx, cervix
	V15.82		Other personal history presenting hazards to health
	V16.3		Family history of malignant neoplasm, breast
	V17.4		Family history of cervical dysplasia
	V67.9		Unspecified follow-up examination
	V70.0		General medical examination
	V71.1		Observation for suspected neoplasm
	V72.31		Routine gynecological exam
	V72.32		Encounter for pap, smear to confirm findings
	V72.6		Special investigations and exams, lab exams
	V76.10		Screening for malignant neoplasm, breast
	V76.11		Screening mammography, high risk
	V76.12		Other screening mammogram
	V76.19		Other screening breast exam
	V76.2		Screening for malignant neoplasm of cervix
*	**V77.1**		Diabetes mellitus
*	**V77.91**		Screening for lipid disorders
*	**V81.2**		Special screening for cardiovascular condition, unspecified

√4th Denotes that a fourth digit is needed to bill for the code in a specific manner.

* These cardiovascular disease screening codes are billable **ONLY** for women 40 years of age and older.

2005 Revenue Codes
For use with UB-92 Claim Form only

Associated with CPT Codes –
Paid at the Medicare-B rate listed on the current Ladies First Fee Schedule

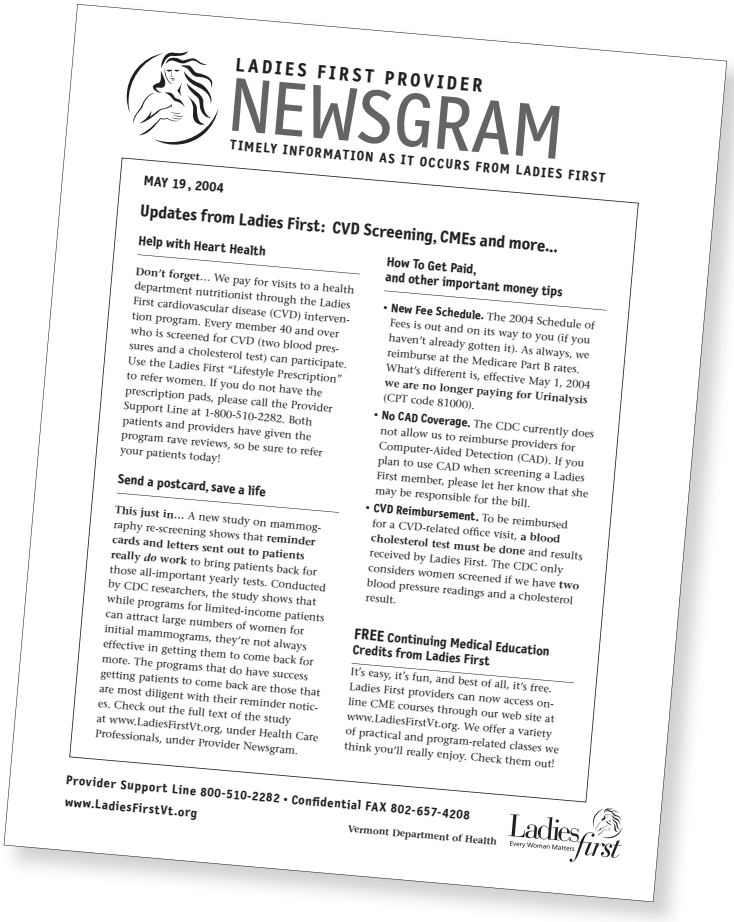
300	Lab General (CVD only)
310	Lab Pathology, General
311	Lab Pathology, Cytology
320	Radiology, General
361	OR Services, Minor Surgery
370	Anesthesia
371	Anesthesia
372	Anesthesia
401	Other Imaging Services, Mammography (**NOT CAD**)
402	Other, Ultrasound
403	Screening Mammography
510	Clinical, General
514	OB/GYN Clinic

BY REVIEW – Extra charges are paid only per itemized review

250	Pharmacy
258	IV Solutions
260	IV Therapy, General
262	IV Therapy – Solutions
264	IV Therapy, Supplies
270	Supplies- Devices, General
271	Non-Sterile Supplies
272	Sterile Supplies
450	ER General
710	Recovery, General
988	Professional Fees, Consultation

Provider Support Services

- **Ladies First administrative services** are available for general questions. Case management services are also available to assist you in arranging follow-up services or resources for any woman enrolled in the Ladies First program.
- At your preference, a one-page **Ladies First Newsgram** will be faxed, mailed or e-mailed to your office, to keep you informed in a timely way of changes to the Ladies First program.
- The **Ladies First program website**, www.LadiesFirstVt.org, offers links to related professional resources, in addition to patient education information, and the latest versions of protocols and resources.
- The Ladies First office maintains a computerized system to track screening and diagnostic results. To assist you with scheduling short-term follow-up appointments for members, Ladies First sends reminder letters to you indicating which members are in need of short-term follow-up. This service is offered only if Ladies First is notified of results and plans for follow-up. This information also helps Ladies First document that all of our members are receiving timely and appropriate care, as mandated by the CDCP.
- Ladies First **Health Outreach Specialists** are based in local Department of Health offices statewide. Their role is to provide outreach and communication about early detection of breast and cervical cancer and CVD risk factors. Health Outreach Specialists are available to provide education and updates to providers. Call the Provider Support Line to arrange for training.



LADIES FIRST PROVIDER
NEWSGRAM
TIMELY INFORMATION AS IT OCCURS FROM LADIES FIRST

MAY 19, 2004

Updates from Ladies First: CVD Screening, CMEs and more...

Help with Heart Health

Don't forget... We pay for visits to a health department nutritionist through the Ladies First cardiovascular disease (CVD) intervention program. Every member 40 and over who is screened for CVD (two blood pressures and a cholesterol test) can participate. Use the Ladies First "Lifestyle Prescription" to refer women. If you do not have the prescription pads, please call the Provider Support Line at 1-800-510-2282. Both patients and providers have given the program rave reviews, so be sure to refer your patients today!

Send a postcard, save a life

This just in... A new study on mammography re-screening shows that **reminder cards and letters sent out to patients really *do* work** to bring patients back for those all-important yearly tests. Conducted by CDC researchers, the study shows that while programs for limited-income patients can attract large numbers of women for initial mammograms, they're not always effective in getting them to come back for more. The programs that do have success getting patients to come back are those that are most diligent with their reminder notices. Check out the full text of the study at www.LadiesFirstVt.org, under Health Care Professionals, under Provider Newsgram.

How To Get Paid, and other important money tips

- **New Fee Schedule.** The 2004 Schedule of Fees is out and on its way to you (if you haven't already gotten it). As always, we reimburse at the Medicare Part B rates. What's different is, effective May 1, 2004 **we are no longer paying for Urinalysis** (CPT code 81000).
- **No CAD Coverage.** The CDC currently does not allow us to reimburse providers for Computer-Aided Detection (CAD). If you plan to use CAD when screening a Ladies First member, please let her know that she may be responsible for the bill.
- **CVD Reimbursement.** To be reimbursed for a CVD-related office visit, **a blood cholesterol test must be done** and results received by Ladies First. The CDC only considers women screened if we have **two** blood pressure readings and a cholesterol result.

FREE Continuing Medical Education Credits from Ladies First

It's easy, it's fun, and best of all, it's free. Ladies First providers can now access online CME courses through our web site at www.LadiesFirstVt.org. We offer a variety of practical and program-related classes we think you'll really enjoy. Check them out!

Provider Support Line 800-510-2282 • Confidential FAX 802-657-4208
www.LadiesFirstVt.org
Vermont Department of Health
Ladies first — Every Woman Matters

Get Answers to Your Questions

- Call our Provider Support Line at **1-800-510-2282** for assistance with any questions regarding the program.
- The Ladies First program website, **www.LadiesFirstVt.org**, offers a Frequently Asked Questions (FAQ) section, in addition to copies of patient education information, and the latest versions of forms and resources.